

Entire application must be completed in ink  
Please print

Group Policy # **6414**

**Health Care Providers Group Insurance Plan  
Application for Optional Group Life Insurance for Children**

Fax copies not acceptable

**Benefits applied for at this time:**

Amount of Insurance

Coverage is available in units of 5,000 to a \$50,000 maximum.

**Applicant information**

1. Status of Applicant:  Child

\* Please provide name of employee and their employer below:

Name of Employee

Employer

2. Name of Applicant :

Sex: Male

Female

Res. Address:

City

Province

Code

Date of Birth:

day

month

year

Telephone number: Home

Business

3. Is Applicant currently insured for this coverage?  No  Yes - Grp./PID#

4. Beneficiary in the event of death of the Applicant ( Designation by Employee only):

Name (full given names):

Relationship to Applicant:

Note: For Child Applications the beneficiary of this insurance will be the employee.

**Applicant's Declaration of Insurability**

5. Have you had any symptoms of, or treatment for, any medical condition, disorder or ailment that resulted in your hospitalization within the last 2 years? Yes  No

If YES, give details below:

Name of Disorder	Date of		Result	Attending Physician or Hospital
	Onset	Recovery		

6. Your height

Your weight

Has your weight changed in the past year?  Yes  No

If YES, how much?

Why?

7. Are you now, to the best of your knowledge and belief, in good health and free from all symptoms of illness and disease?

Yes

No

If NO, give details below:

Name of Disorder	Date of		Result	Attending Physician or Hospital
	Onset	Recovery		

8. Are you now under observation or taking treatment or medication from any physician or alternative health care provider for any disorder, ailment or condition? (Alternative health care provider includes herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy, etc.)

Yes

No

If YES, What?

Why?

9. Who is your regular physician or family doctor?

Address:

Date Last Seen:  Reason and Result:

10. Have you ever had or been told you had any of the following:

- a) Lung or respiratory disorder (e.g. asthma, bronchitis, tuberculosis, emphysema)?  Yes  No
- b) Heart trouble (e.g. pain in the chest, shortness of breath, high blood pressure, rheumatic fever, murmur, heart attack or stroke)?  Yes  No
- c) Stomach trouble (e.g. ulcer, appendicitis, gall bladder, hernia, or other digestive disorder, colitis)?  Yes  No
- d) Diabetes, kidney disease, sexually transmitted disease, or abnormality of the urine?  Yes  No
- e) Cancer, cyst, tumour, growth or blood disorder?  Yes  No
- f) Epilepsy, paralysis, dizziness, nervous or mental disorder?  Yes  No
- g) Neuritis, arthritis, rheumatism, back, spine, bone joint, or muscle disorder?  Yes  No
- h) Nervous disorders, including depression, severe anxiety or suicidal thoughts?  Yes  No
- i) AIDS or an AIDS related complex, or had a positive reaction to a test designed to reveal the presence of Human Immunodeficiency Virus (HIV), or any other immunological disorder?  Yes  No
- j) Hepatitis A,B, C or type unknown, or any other disorder of the liver?  Yes  No
- k) Any disease, impairment or deformity not named above?  Yes  No

If yes to any questions in #10, give details below:

Name of Disorder	Date of		Result	Attending Physician or Hospital
	Onset	Recovery		

11. Have you ever taken drugs, including marijuana and cocaine for other than medical purposes or been advised to reduce alcohol consumption or received or have been counselled to receive treatment for drug addiction or alcoholism?  Yes  No  
If YES, give details:

12. Have you ever been refused life insurance or offered insurance modified in any way?  Yes  No  
If YES, give details including date and reason:

13. Tobacco Use: Have you smoked any Tobacco Products within the past 12 months? (tobacco products include: cigarettes, cigarillos, mini cigars, pipe smoking, chewing tobacco, nicotine gum or patch, marijuana or hashish.)  Yes  No

**Privacy Statement**

Co-operators Life Insurance Company ("Co-operators") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

**Applicant Declaration and Authorization**

The Applicant includes the Parent or Guardian of a child under 16 years of age to be insured

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, any insurance company, provincial health insurance plan, government department or agency, or any other person or organization having any medical or other relevant personal information or records regarding me or my child under age 16 years to release to and exchange with Co-operators, the group plan administrator or their representatives and/or agents, any and all such information necessary for any or all of the following purposes: to underwrite my Application for insurance coverage, evaluate my eligibility for coverage and adjudicate all claims.

I further authorize Co-operators, the group plan administrator or their representatives and/or agents to request I or my child under age 16 years, undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for such purposes.

I understand that my refusal or withdrawal of consent may result in the delay or denial of my Application.

I acknowledge that any information obtained from any paramedical or medical examination, any medical evidence form(s), questionnaire(s) or any other written statements completed and furnished as evidence of insurability shall form part of this Application and I declare that all such information and the information provided in this Application to be true, complete and accurate.

I acknowledge that any failure to disclose or any misrepresentation of any material fact may void the policy.

This authorization shall remain valid until revoked in writing by me. Any copy of this authorization shall be as valid as the original.

Date Signed:

Applicant's Signature (if age 16 or over):

Employee Signature:

Parent or Guardian Signature (application for child under age 16 years):

I wish to apply for the optional coverage under group policy # \_\_\_\_\_ Account# \_\_\_\_\_ PID# \_\_\_\_\_ issued by Co-operators Life Insurance Company, and authorize my employer to deduct regularly from my salary and contribution required by me.

**This form must be received in our office within 60 days of the above date otherwise a new application must be completed.**